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ABSTRACT

This paper describes the Gerontology Alcohol Project (GAP), which was established by the National Institute of Alcoholism and Alcohol Abuse as a pilot treatment/research project for late life drinkers, those who begin abusing alcohol after age 50. Two strategies developed by GAP for identifying elderly alcohol abusers are described including identifying characteristics (quantity and frequency of consumption, quality of life indicators), and source of referral to the program. Four treatment strategies are discussed: (1) breaking the drinking behavior down into component parts (antecedents, behavior, and consequences); (2) dealing with the identified antecedents of the behavior (depression, anxiety, anger, relapse); (3) problem solving skills; and (4) an alcohol education group. Effects of the program and the present status of the GAP project are reviewed. A comparison of (1) late-life versus early-onset alcohol abusers, (2) abusers versus clients without alcohol abuse, and (3) program dropouts versus program graduates is presented. (JAC)

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STRATEGIES FOR RECOGNIZING AND TREATING ELDERLY ALCOHOL ABUSERS

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STRATEGIES FOR RECOGNIZING AND TREATING ELDERLY ALCOHOL ABUSERS

The population of the United States is an "aging population", in that the projected census for the year 2000 predicts that there will be 35 million people age 65 or older, an increase of 37% from the 1980 census (United States Bureau of Census, 1980). In the state of Florida, the percentage of elderly residents has been higher than the national average. In 1980, 16% of the state's population (1.6 million people) was over age 65. This will increase to about 21% (3.2 million) by the year 2000 (Thompson, Terhune, and Floyd, 1979).

As the percentage of elderly individuals increases, problems specific to this age group will be of increasing concern. The aging process exposes the elderly to various losses (usually cumulative or multiple) not typically experienced with other age groups. These include: loss of employment, death of a loved one with whom they had long relationship, a change in residence, diminution of social contacts, physical changes, and changes in mood states (e.g. depression).

Previous literature has reported that alcohol consumption declines with age and that abstinence is more prominent (Mishara and Kastenbaum, 1980). However, recent research indicates that alcohol abuse among the elderly is a significant problem, with varying estimates . For example, Zimberg (1974; 1978) and Zimberg, et al. (1978) estimated that, in the United States, 10 to 15 percent of elderly individuals (age 55 or older) who reside in the community experience alcohol related problems. This figure could represent as few as 6.9 million elderly people. Simon, et al. (1968) found that 30 to 40% of the elderly admitted to mental health facilities abused alcohol.

Elderly alcohol abusers have been divided into two categories: the aging alcoholic, who began drinking early in life but who survived into old age; and the geriatric problem drinker, of which there can be two types, those who have had intermittent problems with alcohol in the past and who abuses it regularly in old age, or the person with no history of alcohol abuse until late-life (Zimberg, 1974; 1978; Schuckit, 1977; Rosin & Glatt, 1971).

The Gerontology Alcohol Project

The Gerontology Alcohol Project (GAP), a pilot treatment/research project funded by the National Institute of Alcoholism and Alcohol Abuse, (Dupree, Broskowski, and Schonfeld, in press; Dupree and Schonfeld, 1984) first addressed the "later-life onset alcohol abuser" or "late-life drinker", i.e., the individual over age 55 who began abusing alcohol after age 50. GAP attempted to answer three research questions about these elderly individuals: 1) Did they exist as a clinical entity? 2) What methods could be used to identify and enter them into our treatment program? 3) What treatment methods, specific to these individuals were appropriate, testable, and replicable by others in the treatment/research field?

GAP used a behavioral and self-management approach to treatment. Clients were taught methods to identify the components (antecedents, behavior, consequences) of their personal behavior chains, and methods to deal with the antecedents and consequences and thus, "break the chain". Dupree et al., (in press) showed that a substantial number of late-life drinkers existed (50.3% of the elderly alcohol abusers referred). However, due to a lack of "leverage" only 48 clients agreed to participate and only half (24) completed the program and participated in a one year follow up. The results of the pilot program were encouraging. No "program completer" or "graduate" resumed steady drinking, and 74% of the graduates maintained their drinking goals.

Strategies Used To Recognize Elderly Alcohol Abusers

From the GAP research, two aspects of strategies were developed for identifying elderly alcohol abusers and entering them into treatment. The first aspect includes the identifying characteristics, i.e., what symptoms exist to indicate a problem with alcohol? The second aspect addresses the method for referral to the program of a person with a possible problem.

Identifying Characteristics

According to Pattison, et al. (1977) the best method of identifying individuals with alcohol problems is to consider "multiple measures", i.e., in addition to the quantity and frequency of alcohol consumed, it is necessary to consider what other aspects of one's life are affected by alcohol abuse. The "quality of life indicators" include an individual's mental health, physical health, occupational/financial problems, family and social relationships, and legal problems.

The elderly present a different, more difficult problem for identifying alcohol abuse. Since many of our clients did not drive, DWI's were relatively uncommon and most were not physically capable of assault legal problems may not be the best indicators of a problem. Similarly, almost all of our elderly clients were retired; hence there were no employers or co-workers to identify a problem. The elderly as a whole have diminished social support networks and fewer family contacts, therefore there are fewer opportunities to notice how the individual has changed due to alcohol consumption.

By having fewer opportunities to measure the quality of life indicators it would seem that elderly alcohol abusers can be considered "hidden abusers". This is especially true for those individuals, such as the late-life drinker, who are unfamiliar with community services and treatment. Thus, while Pattison's suggestions are valuable, they are not easily applied to the late-life drinker.

Referral Sources for Recognizing the Elderly Alcohol Abuser

GAP developed three methods for gathering referrals from the community: Mass media (news articles, advertisements, public service announcements) was used to advertise the general public; GAP staff attempted to screen individuals visiting public health clinics; and a "referral network" of approximately 21 service providing agencies and hospitals was established. The vast majority of referrals were made via the referral network. Most referrals came from social workers and agents from other care providers such as medical facilities, psychiatric facilities, and apartment complexes for the elderly. The mass media required high expenditure and repeated attempts to obtain a relative few referrals. The health clinics provided only a few referrals.

Most referrals were made by agencies who were not in the alcohol treatment field. This indicated further evidence of the elderly individuals being hidden abusers in that they had no previous contact with alcohol treatment.

Strategies Used to Treat Elderly Alcohol Abusers

Marlatt and Gordon (1980) have indicated that if an individual's antecedents to drinking are not attended to, relapse becomes predictable. Our research has indicated that the elderly typically drink at home, alone, and in response to depression. Many are alone due to the death of a spouse or divorce.

Our program (Dupree, et al., in press) consists of 4 major approaches. First it attempts to teach the elderly individual to analyze or break down their personal drinking behavior chain into its components (antecedents, behavior, and consequences) as well as instructing them in the methods of monitoring their own behavior. Second, when the individual can identify these successfully we then teach them (via behavior rehearsals, lectures, practice) the methods to deal with the identified antecedents of their behavior. Using this behavioral/self management approach within a group format, the individuals enter training to deal with depression, drink refusal, cues for drinking, urges to drink, relapse, tension/anxiety, and anger/frustration (assertiveness). Third, clients are taught general problem solving skills so that they will be able to deal with <u>any</u> problem situation (antecedent) which may arise in the future. Fourth, the consequences of their alcohol abuse are attended to via an alcohol education group. Finally, as Zimberg (1974) had proposed, we teach the elderly individual the skills necessary for him/her to expand their social support network using similar techniques (rehearsal, practice, lectures). The results of our program indicate that the participants within our program have improved their abilities to analyze their behavior, deal with possible antecedents identified as problems specific to them, and understand the consequences of alcohol abuse.

Present Status of GAP

At the end of the three year NIAAA grant GAP became incorporated within the previously existing Community Aging Program, a day treatment program for treating elderly individuals at risk of being institutionalized for mental health problems. At the same time, the criteria for entering treatment for an alcohol problem was broadened to include all elderly alcohol abusers regardless of age of onset. Furthermore, many of the group treatment approaches or modules developed for the GAP were found to be useful for our general mental health population (e.g. modules such as: General Problem Solving Skills; Self Management of Depression, Anger/Frustration, Anxiety/Tension; and Social Support Network).

These recent changes have allowed us to make comparisons among different categories of clients admitted to the Community Aging Program. We can now compare "late-life" with "early-onset" drinkers; mental health clients without alcohol abuse with those admitted for alcohol abuse; and program graduates (who completed treatment) with program dropouts.

Late-Life vs. Early Onset Alcohol Abusers

Only preliminary comparisons of these two categories can be made since relatively few early-onset drinkers have been admitted. As of July 31, 1984 we have treated 85 elderly alcohol abusers, of which 69 could be classified as late-life and 16 classified as early onset. In summary, the early-onset drinkers, were somewhat younger, consumed a higher quantity of alcohol, showed slightly higher indices of mental illness, and had a higher dropout rate. As is obvious, these people frequently had a long history of alcohol treatment and more exposure to Alcoholics Anonymous.

Alcohol Abusers vs. Clients Without Alcohol Abuse

Analysis of variance indicated that clients admitted for alcohol abuse were younger, better off financially, and better educated than the "non-abusers". On assessments of levels of functioning (Community Adjustment Potential scale; Nurses Observation Scale of Inpatient Evaluation; WAIS verbal IQ; and such assessments of module related skills such as Activities of Daily Living) the alcohol abusers demonstrated superior scores.

Program Dropouts vs. Program Graduates

In our pilot study, we noted a 50% dropout rate. This is not uncommon in outpatient populations (Baekeland & Lundwall, 1975). However, the differences we observed in that study helped us make some changes within our program which we hope will reduce dropout rates among all of our Community Aging Program's clients. At admission, the characteristics demonstrated that for alcohol clients, dropouts had a lower personal estimate of achieving success within our program; higher depression scores; a more "internal" locus of control; and tended to consume more alcohol than program graduates.

Preliminary analyses of nonalcohol abusers have yet to indicate similar differences. However, we now attend to higher depression scores and lower expectancies at admission in an attempt to lower the dropout rate of all clients.

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Table 1

Differences Between Late-Life and Early Onset Elderly Drinkers

	Late Life	Early Onset
Age told they had a problem	57.8	32.5
Age felt they had a problem	57.4	40.6
% Who sought outside help	59.3	85.7
% Who ever attended AA	39.0	71.4
Average daily alcohol consumption (SEC units)	12.0	24.3
Beck Depression Score	11.4	14.9

Table 2

Differences Between Elderly Alcohol Abusers and Mental Health Clients

	Alcohol	Mental Health
Mean Age	64	71
% Who live alone	41	18
% High School Graduate	71	46
Community Adjustment Potential	65	54
WAIS-verbal IQ	114	94